(b) Insurance Code Section 10127.14 is added to read as follows:
Section 10127.14.

All contracts for health or disability insurance must comply with the requirements of Health and Safety Code § 1363.1, relating to pre-dispute arbitration agreements, Health and Safety Code § 1373.20 relating to arbitration procedures, Health and Safety Code § 1373.21 relating to reporting, and Health and Safety Code § 1373.22.

SECTION 3 [Arbitration Procedures]

(a) Health and Safety Code Section 1373.19 is hereby repealed:

(b) Health and Safety Code Section 1373.20 is amended to read as follows:
Section 1373.20

(a) All disputes arbitrated more than thirty days after the Effective Date of this Act, between health care service plans and their enrollees shall be subject to the following rules.

(b) The Department of Managed Health Care must establish a panel of arbitrators acceptable to the Director, by thirty days after the Effective Date of this Act.

(c) When an arbitration is initiated, the health care service plan must inform the Department, which must assign, within 15 days, by a mechanical or electronic randomization procedure, one neutral arbitrator to hear the case.

(d) The Arbitrator may be challenged by the parties only for such cause as would be valid for disqualifying a judicial officer, as set forth in Section 170.1 of the Code of Civil Procedure. Peremptory challenges shall not be allowed.

(e) The health care service plan must be responsible for all arbitration expenses greater than those of a corresponding court proceeding.

(f) Pre-hearing discovery procedures must be made available to enrollees, as in court proceedings.

(g) Procedural safeguards must be provided, at least some subset of the

Rules of Civil Procedure, to be determined by the Director.

(h) While the arbitrator may relax procedural rules, he must apply substantive law.

(i) Judicial appeals from the arbitrator's decision must be available for abuse of discretion or legal or factual error, on the same grounds as from that of a court.

(j) At the completion of the arbitration, the arbitrator must provide a written decision, naming the parties and witnesses, outlining the evidence and law relied upon, including evidence proffered but not admitted, and describing any awards, and the rationale therefore.

(k) Every health plan contract providing for binding arbitration must provide that any breach of the contractual or statutory arbitration rules by the plan, or its missing any contractual arbitration time requirements by thirty days or more, shall constitute waiver of the plan's right to enforce arbitration.

(l) The hourly fee for an arbitrator assigned by the Department pursuant to this section shall be the current annual salary of a superior court judge divided by Two Thousand (2000) plus reasonable travel expenses. No additional fee or gift may be given to any arbitrator by any party.

SECTION 4 [Reporting of decisions and settlements]

Health and Safety Code Section 1373.21 is amended to read as follows: Section 1373.21

(a) All health plans must provide to the Director of the Department of Managed Health Care, within 30 days of completion by decision or settlement, a complete report of all arbitrations and litigations with enrollees. These reports must indicate the names of all parties, the amount, other relevant terms, and the reasons for any award rendered, the name of the arbitrator or arbitrators, providers, health plan employees, and health facilities involved, as well as the complete written decision and a list of all evidence submitted to the arbitrator or judge, whether admitted by him or not.

(b) All documents relating to the arbitration or litigation, including but not limited to written decisions, deposition testimony, expert testimony, the record of the proceedings and all documents produced in discovery must be preserved by the plan for five years, and provided to the Director within thirty days of his written demand within that time.

(c) The Director or the Department of Managed Health Care must not make public any enrollee or patient-identified medical information without the written consent of the enrollee or patient, except as mandated by law.

(d) Unless confidentiality is required by law, court and arbitration records are presumed to be open.

(e) Any party may seek a court order to seal the records obtained by DMHC, subject to the qualification of 2001 California Rules of Court 243.1, i.e.: if the court expressly finds that:
(1) There exists an overriding interest that overcomes the right of public access;

(2) The overriding interest supports sealing the record;

(3) A substantial probability exists that the overriding interest will be prejudiced if the record is not sealed;

(4) The proposed sealing is narrowly tailored; and

(5) No less restrictive means exist to achieve the overriding interest.

(f) The Department may disclose the identity of physicians involved in actions against plans, under the same conditions the Medical Board would apply, as required by Business and Professions Code §803.1.

(g) Subject to sections (c),(d),(e),and (f) above, the Director must make public, in the Department's reading room and on the Internet, all records, including discovery materials used or submitted as a basis for adjudication, relating to arbitrations, litigations or settlements.

(h) These records may be used in compiling the "report cards" required by Health and Safety Code §1368.02(c)(3)(B).

SECTION 5 [Miscellaneous]

Health and Safety Code Section 1373.22 is added to read as follows:
(a) Interpretation and Precedence "This Act" consists of Health and Safety Code sections 1363.1, 1373.20, 1373.21 and 1373.22, and Insurance Code Section 10127.14.
This Act shall be liberally construed and applied to promote its underlying purpose, which is to preserve the access of HMO enrollees to the courts. The provisions of this Act shall take precedence over any statute, regulation or decision in Common Law that may conflict with or limit the most expansive interpretation of these provisions for the protection of every person.

(b) Amendment No provision of this Act may be amended by the Legislature except to further the purpose of that provision by a statute passed in each house by roll call vote entered in the journal, two-thirds of the membership concurring, or by a statute that becomes effective only when approved by the electorate. No amendment by the Legislature shall be deemed to further the purposes of this Act unless it furthers the purpose of the specific provision of this Act that is being amended.

(c) Effective Date The provisions of this Act shall become effective upon passage of the Act and shall apply to all acts or practices performed or contracts entered into from that date forward.

(d) Legal Challenges It is the will of the People of California that any legal challenge to the validity of any provision of this Act shall be acted upon by the Courts on an expedited basis and any fees or costs incurred by the taxpayers in connection with the defense of the Act shall be promptly repaid to the taxpayers by any person challenging the Act.

(e) Severability If any provision of this Act or the application thereof to any person or circumstance is held invalid, that invalidity shall not affect any other provision or application of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable. It is the will of the People of California that any invalid section, subdivision, paragraph, sentence, clause, phrase or word shall be severed from the remainder of the Act to preserve its remaining provisions.